COUPE HEALTH

Coupe Health Benefits Summary

Client Name: Warners' Stellian High Deductible Plan (HSA-Compatible)
Plan Year: January 1st, 2026 - December 31st, 2026
Network: BlueCard® PPO Network

Medical Benefits

	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	
Calendar Year Deductible (Indiv/Family)		$2,000 / $4,000		$4,000 / $8,000
Out-of-Pocket Maximum (Indiv/Family)		$4,000 / $8,000		Unlimited
*OOP Max applies to in-network services only				

	In-Network			Out-of-Network
Medical Services	Tier 1	Tier 2	Tier 3	
Physician Services				
Primary Care Physician	$20	$25	$40	$50
Retail Health Clinic	$20	$25	$40	$50
Specialist	$35	$50	$90	$100
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)		No Charge		$100
Adult Physical Examination (including routine GYN visit)		No Charge		$100
Routine Eye Care		No Charge		$100
COVID 19 Vaccine		No Charge		$100
Breast Cancer Screening (any age)		No Charge		$100
Pap Test		No Charge		$100
Prostate Cancer Screening		No Charge		$100
Colorectal Cancer Screening		No Charge		$100
Telehealth Services				
Doctor on Demand		$20		N/A
Maternity				
Initial Prenatal Office Visit	$20	$25	$40	$50
Prenatal Office Visit		No Charge		$50
Delivery & Postnatal Care	$1,640	$2,180	$3,300	$3,900
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$1,640	$2,180	$3,300	$3,900
Outpatient Hospital	$540	$720	$1,210	$1,450
Skilled Nursing /Rehabilitation Facility (120 days combined max per plan year)	$1,450	$1,920	$3,300	$3,900
Ambulance Services		$265		
Ambulatory Surgical Center	$540	$720	$1,210	$1,450
Home Health Care (120 visits per plan year)	$35	$50	$90	$100
Home Infusion	$35	$50	$90	$100
Hospice Care	$180	$240	$410	$490

	In-Network			Out-of-Network
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	
Radiology Services				
Diagnostic X-Rays	$50	$65	$110	$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$170	$220	$370	$440
Laboratory Services				
Basic Labs	$15	$20	$30	$40
Advanced Diagnostic Labs	$50	$70	$110	$125
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$265			
Urgent Care Facility	$30			
Mental Disorders & Substance Use Disorders				
Office Visit	$20	$25	$40	$50
Inpatient	$1,640	$2,180	$3,300	$3,900
Outpatient	$540	$720	$1,210	$1,450
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visits per plan year)	$35	$50	$90	$100
Outpatient Therapies (PT, OT, ST) (60 visits per plan year)	$35	$50	$90	$100
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	$75	$100	$170	$210
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$35	$50	$90	$100
Acupuncture	$35	$50	$90	$100
Transplants (Travel/lodging $5,000 lifetime maximum)	$1,640	$2,180	$3,300	$3,900

Pharmacy Drug Vendor: Prime Therapeutics Rx

Pharmacy Benefits	
NOTE: There is no coverage under the plan for prescription drugs obtained from a Non-Participating Partner.	
Rx Network: **Select Pharmacy Network** Rx Formulary: **FlexRx**	If you reach your out-of-pocket maximum, the plan will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All copays and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Pharmacy Plan Feature	
Retail Pharmacy (30-Day Supply)	
FlexRx Preventive Drugs	$0
Preferred Generic Drugs	$10
Non-Preferred Generic Drugs	$10
Preferred Brand Drugs	$15
Non-Preferred Brand Drugs	$20
Specialty Drug Program	
Specialty Drugs* (Up to a 30-day Supply)	$200
*Specialty medications are required to be filled through a Specialty Pharmacy.	
Mail Order (90-Day Supply)	
Preferred Generic Drugs	$20
Non-Preferred Generic Drugs	$20
Preferred Brand Drugs	$30
Non-Preferred Brand Drugs	$40
Drug Descriptions	
Preferred Generic Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Generic Drugs	All non-preferred generic drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.
Preferred Brand Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Brand Drugs	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.